Supreme Court, U. S.
FILED
AUG 8 1978
MICHAEL RODAK, JR., CLERK

In the Supreme Court of the United States

No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

BRIEF FOR APPELLANTS

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OPINIONS BELOW

The original majority and dissenting opinions of the District Court are reported at 402 F. Supp. 1039 and are set forth in the appendix at (783a-823a). The decision of the majority and dissent, not yet reported, are set forth in the appendix at (1051a-1115a).

JURISDICTION

The decision of the District Court and its final order were entered on May 25, 1978 (1051a). This appeal was docketed on May 31, 1978 and probable jurisdiction noted on June 19, 1978. The jurisdiction of this Court is conferred by Title 28 U.S.C., Section 1253.

STATUTES AND REGULATIONS INVOLVED

Statutes

Mental Health and Mental Retardation Act of 1966, 50 P.S. §4402 et seq.

§4402. Voluntary admission; application, examination and acceptance; duration of admission

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application for admission has been made under the provisions of section 402 (a) (2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

(d) Each admission under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is admitted, to determine whether continued care is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation may permit.

Where the admission is under the provisions of section 402 (a) (2), the person admitted shall be informed at least each sixty days of the voluntary nature of his status at the facility.

§4403. Voluntary commitment; application, examination and acceptance; duration of commitment

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

(d) Each commitment under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is cared for, to determine whether continued care and commitment is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation shall permit.

Where the commitment is under the provisions of section 403 (a) (2), the person committed shall be informed at least each sixty days of the voluntary nature of his status at the facility.

§4426. Habeas corpus; discharge by order of court

(a) Every person committed or detained in a facility by reason of the provisions of this act or anyone acting on his behalf, may at any time, petition for a writ of Habeas Corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the act of May 25, 1951 (P.L. 415).

(b) Said petition may be based upon the following grounds:

(1) The insufficiency or illegality of the proceedings leading to such person's commitment, or,

(2) Although the commitment proceedings were proper, such person's continued detention or hospitalization is not warranted by reason of mental disability. Where the petition is based on this ground: (i) it shall be accompanied by the affidavit of a physician stating that he has examined the person and is of the opinion that such person is not mentally disabled, or that such mental disability does not require care or treatment in a facility, and (ii) the burden of proof shall rest upon the director responsible for such person's continued detention.

(c) Jurisdiction and venue is hereby conferred upon the several courts of the Commonwealth to issue writs of Habeas Corpus filed under this act as follows:

(1) A petition filed under section 426 (b) (1) may be filed: (i) where committed by a court, only in the same court, or (ii) where committed under sections 404 or 405 of this act, only in the court of the county where the application for commitment was made.

(2) A petition filed under section 426 (b) (2) may be filed: (i) in the court which committed such person or the court of common pleas of the county where he is detained if a civil commitment was ordered, or (ii) where a criminal charge is pending, in the court having jurisdiction of the charge or which committed him or the court of the county where he is detained, or (iii) where committed by a court where a criminal act was in any way otherwise involved in the proceedings leading to commitment, only in the same court which committed such person.

(3) If any petition under section 426 (b) (2) is filed in a court other than the court of the county in which the person is detained, the petition may be transferred for disposition by the court in which it was filed to the appropriate court of the county in which the person is detained.

Mental Health Procedures Act of 1976

§7201. Persons who may authorize voluntary treatment

Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

1976, July 9, P.L. 817, No. 143, §201, effective in 60 days.

§7205. Physical examination and formulation of individualized treatment plan

Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by

a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

1976, July 9, P.L. 817, No. 143, §205, effective in 60 days.

§7206. Withdrawal from voluntary inpatient treatment

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203.1 he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may effect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in

accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commission of Mental Health or his designate.

1976, July 9, P.L. 817, No. 143, §206, effective in 60 days.

Regulations

Volume 3, Pennsylvania Bulletin, p. 1840 Department of Public Welfare

Additional Procedural Safeguards for Juveniles Admitted to Institutions

The Department of Public Welfare by this Order adopts additional procedural safeguards for juveniles admitted to institutions pursuant to §402 and §403 of the Mental Health and Mental Retardation Act.

Notice of the proposed rule making was published in 3 Pa. B. 536, March 24, 1973.

After consideration of the views presented by interested persons, the regulations are adopted with some changes. Additions have been made in Paragraphs 1, 2, 6, 7 and the form of notification to permit referral of mentally retarded juveniles to institutions by either a pedia-

trician, or general physician or psychologist. A new paragraph has been written to reflect whether the juvenile is capable of understanding the notification form. In these regulations, the word "applicant" shall refer to the person who signed the juvenile in while the word "juvenile" shall refer to any youth 18 years of age or younger. Several comments urge that the role of the Public Defendant's Office be replaced by a legal service program; however, the Public Defender Act, December 2, 1968 P.L. 1144, (No. 358) §1 *et seq.*, (16 P.S. 9960.6(a), (c), specifically makes the Public Defender responsible for persons who are or may be subject to commitment under the Mental Health and Mental Retardation Act of 1966. To the extent, however, that Legal Services other than the Public Defender are readily available, such Legal Services may be utilized in lieu of the Public Defender's Office and §5, §6 and §9 of these regulations have been changed accordingly. These regulations shall not be interpreted to permit direct intake into state-operated facilities. Although the Department is adopting these regulations, it will evaluate the procedures at the end of six months. If necessary the Department will at that time hold public hearings.

The regulations hereby adopted are adopted pursuant to Article 2, §201 of the Mental Health and Mental Retardation Act of 1966, Act of October 20, 1966, No. 6, Third Special Session.

The Department of Public Welfare finds:

1. That public notice of intention to adopt the administrative regulations adopted by this Order has been duly given pursuant to §§201 and 202 of the Commonwealth Documents Law (45 P.S. §§1201 and 1202) and the regulations thereunder, 1 Pa. Code §§7.1 and 7.2.

2. That the adoption of the regulations in the manner provided in this Order is necessary and appropriate for the administration of the Mental Health and Mental Retardation Act of 1966.

The Department of Public Welfare, acting pursuant to the Public Welfare Code, and the Mental Health/Mental Retardation Act of 1966, orders:

(A) The regulations of the Department of Public Welfare are amended to read as set forth in Annex A to this order.

(B) The Secretary of the Department of Public Welfare shall submit this Order and Annex A hereto to the Department of Justice for approval as to legality as required by law.

(C) The Secretary of the Department of Public Welfare shall duly certify this Order and Annex A hereto and deposit same in the Legislative Reference Bureau as required by law.

(D) This order shall take effect upon publication.

(s) _____

Secretary of Public Welfare

ANNEX A

Rules Relating to Persons 18 Years of Age or Younger Admitted to Mental Health or Mental Retardation Institutions Pursuant to §§402 and 403 of the Mental Health and Mental Retardation Act

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist.

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

3. The Director of the Institution or his delegate, shall have conducted an *independent* examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate, shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that

he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, *if he feels it is necessary for the youth to remain,* may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director or, his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile.

8. If the staff members of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

9. Juveniles aged 13 and older shall be given the following notice:

RIGHTS OF CHILDREN UNDER §402 and §403

You have currently been admitted to the———— ————Institution for observation and treatment. This voluntary admission procedure was instituted by ———— on ———— (date). You can call the applicant at Telephone Number ———— ———— or you can write the applicant at ———— ————. The purpose in having you admitted to this facility is to help you overcome problems you are experiencing and to return you to the community as soon as possible. Before we accepted you, you must realize that a (circle which one) psychiatric, medical, or psychological opinion was given to us by ————. Also, the Director of this Institution had a (circle which one) psychiatric, medical, or psychological examination conducted so that he could be thoroughly appraised and certain that you could benefit in receiving care and treatment at this Institution.

If you object to remaining in this Institution, you are advised that we shall contact the Public Defender's Office to make other suitable arrangements to obtain legal counsel for you. We will provide you with the telephone number of the attorney who has been contacted on your behalf. We will require two working days from date of your objection to remain, in order to make certain that you will be afforded counsel. At the same time, the Director, or his delegate, of this Institution shall notify the applicant of his desire to require you (sic) hospitalization for your benefit.

A member of our staff shall explain this written letter to you and we ask you to sign it, which will evidence that you have a copy of this letter and that it has been

explained to you in detail. In the event that you have any questions, you can direct them to the person who is explaining this document to you or you may contact this office.

————————

Superintendent's Signature

————————

Patient's Signature

————————

Staff Member's Signature
Giving Notice to Patient

QUESTIONS PRESENTED

I. Whether the Due Process Clause of the Fourteenth Amendment is implicated when a parent admits his child for medically-recommended in-patient mental health or retardation treatment?

II. Whether the admissions of children to private mental health or mental retardation facilities constitute state action for purposes of the Fourteenth Amendment?

III. Whether the District Court erred in its certification of the Plaintiff and Defendant Classes?

IV. Whether retroactive aspects of the lower Court's order are proper?

STATEMENT OF THE CASE

A. History of the Proceedings:

In 1971 and 1972 each of the original plaintiffs were admitted to Haverford State Hospital for in-patient psychiatric therapy.[1] Each of these admissions was effectuated by the child's parent or parents acting in concert with a physician, pursuant to Section 4402 or 4403 of Pennsylvania's Mental Health and Mental Retardation Act of 1966 (the "1966 Act"). According to the terms of that statute, they each received a complete psychiatric examination prior to his admission to determine whether or not such treatment was necessary.

Pennsylvania law, however, did not require that children be provided an adversarial hearing where, with the assistance of counsel, they could challenge the wisdom or medical basis for seeking inpatient therapy. Accordingly, this lawsuit was commenced on November 16, 1972, challenging the constitutionality of this statute on due process grounds (23a). On behalf of a class,[2] they

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[1] The original plaintiffs, Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, and Mark Weand were juveniles afflicted with mental illness as opposed to mental retardation.

[2] Originally the plaintiff class was composed of: "all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (Act)." Moreover, the court specifically noted that this description was intended to encompass both emotionally ill and mentally retarded children (783).

sued the superintendent of the hospital as well as various officials of the Pennsylvania Department of Public Welfare seeking a broad array of injunctive relief including a pre-admission adversarial hearing with the right of counsel. The plaintiffs focused only upon what they perceived to be an unconstitutional admission procedure,[3]—asserting no claim, nor offering any evidence whatsoever that their care was inadequate or inappropriate.

Because the questions involved were substantial, and in view of the injunctive relief requested, a three-judge court was convened pursuant to 28 U.S.C. §2281. Finding the statute unconstitutional on Due Process grounds, a majority of the district court entered an injunction requiring that the defendants provide; (1) a "probable cause hearing" within seventy-two hours of hospitalization (defendants were required to serve prior written notice of that hearing upon the child and his attorney at least forty-eight hours beforehand); (2) a "post-commitment hearing" within two weeks of hospitalization (with a similar prior notice requirement); (3) "Counsel at all significant stages of the commitment," (4) the right to

[3] Shortly after this lawsuit was commenced the Pennsylvania Department of Public Welfare promulgated regulations augmenting Sections 402 and 403 as they pertained to juveniles (supra). These regulations greatly expanded the procedural protections afforded juveniles. Briefly, they require not one, but two independent psychiatric or psychological examinations prior to admission, each indicating the necessity for hospitalization. In addition, each child thirteen years of age or older receives written notice of all his rights under the regulations including the right to be provided free counsel, and the right to a hearing upon objection in any manner whatsoever to the continued inpatient therapy.

be present at all hearings and to confront and cross-examine witnesses as well as to present testimony on their own behalf. And finally, the Court ordered that, within 120 days, each of the thousands of children then hospitalized in mental health facilities throughout Pennsylvania either be discharged or recommitted in accord with the newly mandated procedures (843a-852a).

An appeal was taken to this Court and probable jurisdiction noted. However, while that appeal was pending the Pennsylvania legislature enacted the Mental Health Procedures Act[4] which repealed the challenged statutes only insofar as they applied to mentally ill children. After argument, this Court vacated the district court's opinion and remanded the case for further consideration in light of the changed circumstances occasioned by this new legislation. *Kremens v. Bartley*, 431 U.S. 119 (1976).

On remand the plaintiffs amended and supplemented their complaint adding representative plaintiffs, and a proposed class of defendants.[5] However, they did not alter the theory of their claim, premising their challenge to both the 1966 and 1976 Acts on the Due Process Clause of the Fourteenth Amendment.

[4] 50 Pa. Stat. Ann. §7101 *et seq.* (hereafter referred to as the "1976 Act").

[5] The plaintiffs sought and the district court certified a defendant class composed of:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare (956a).

As will be discussed later, this class includes the directors of private facilities, community-based group homes and mental health centers, as well as private schools "approved" to dispense mental health or retardation therapy.

On May 25, 1978, the district court entered its decision, once again declaring the challenged statutes unconstitutional, and enjoining their enforcement. Specifically, the district court again ordered that every child admitted by his parents to a mental health facility, whether public or private, be provided two separate adversary hearings commencing no later than three days after the admission. The hearings remained exactly as originally ordered—one to determine "probable cause", of the illness or retardation and the other to establish the medical need for in-patient treatment. In addition to these hearings, the children were again provided the rights of prior notice, free counsel,[6] as well as confrontation and cross-examination of adverse witnesses. Finally, all children presently receiving treatment in any of the hundreds of facilities in Pennsylvania were ordered to be either discharged or readmitted pursuant to those procedures within one hundred and eighty days. Shortly after the District Court's Order was entered, this appeal was initated, seeking review of both the declaratory and injunctive aspects of the order.

B. The Admission Process: An Overview

Under the 1966 Act, which only applies to the mentally retarded, there are three general means by which one may be admitted to in-patient residential care: voluntary (§402 and §403), emergency (§405), and involuntary

[6] The Order refers to a "trained representative" as an acceptable alternative to counsel. However in the context of all of the mandatory formalities of the hearings established by the District Court, it is difficult to imagine how a non-lawyer could effectuate and protect all of the rights provided to the children, such as confrontation and cross-examination.

(§406). The first, voluntary admission, is the focus of this litigation. Under these provisions only persons eighteen and over may voluntarily admit themselves for necessary examination and care. Children, on the other hand, must be admitted and for that matter, withdrawn by their parents or guardians, 50 Pa. Stat. Ann. §4402 and §4403.

Similarly, under the 1976 Act, which applies to the mentally ill, there are three parallel procedures: voluntary (§7201), involuntary (§7301), and emergency (§7302). Again it is the voluntary procedure which is under attack here, because it distinguishes between adults and children by allowing parents or guardians to voluntarily admit their children for inpatient treatment.[7] Appellees contend that these procedures violate the mandate of the Due Process Clause by, in effect, allowing their parents to involuntarily admit them for needed medical and psychological treatment without the full panoply of traditional Fourtheenth Amendment procedural protections, *viz.*, prior notice, counsel, and adversary hearing.

Several other features of the Pennsylvania system of mental health admissions bear noting. First, any person committed to a mental health facility may test the validity of his custody by petitioning for a writ of habeas corpus in state court. 50 Pa. Stat. Ann. §4426; 50 Pa. Stat. Ann. §7206. Moreover, a patient may demand an independent psychiatric evaluation to assure the accuracy of the diagnosis and recommendation for his admission to the facility. E.g., 50 Pa. Stat. Ann. §4423-(7). Additionally, the director of any facility must discharge any

[7] Under the 1976 Act the age of majority is fourteen, contrasted with eighteen under the 1966 Act.

patient when that patient no longer needs care and treatment in the facility. 50 Pa. Stat. Ann. §4418, §4420, §7206(c).

Finally, the Pennsylvania Department of Public Welfare promulgated regulations under both Acts. These regulations augment Sections 4402 and 4403 of the 1966 Act, and Section 7201 of the 1976 Act as they apply to juveniles. Although the general effects of these regulations have already been highlighted, it is important to examine all of these provisions more closely at this point. Parts 2 and 3 of the regulation under the 1966 Act guarantee that no juvenile may be admitted to a Pennsylvania retardation facility unless two independent psychiatric examinations reveal that admission is necessary and appropriate. If the results of these examinations do not agree on the need for hospitalization, the child may not be admitted. Additionally within 24 hours of admission, every child over 13 years of age must be given oral and written notice of his rights, including the right to receive periodic reports of his condition, the right to privately communicate with family and counsel, and, if necessary, the right to be furnished counsel. If a juvenile over thirteen years of age objects to continued treatment in the institution, counsel is immediately notified, as are all other interested parties. At this point, the child's hospitalization may continue for a maximum of two business days during which appropriate proceedings must be commenced under Section 4406 of the Act, or the child must be discharged.[8]

[8] There is a possibility of a slightly extended institutionalization in the situation where the director of the facility involved cannot locate the applicant (parent or guardian) and continued hospitalization is recommended. In this case an involuntary civil commitment (§4406) is then instituted by the appropriate local mental health referral and treatment agency.

Similarly, under the 1976 Act a complete medical examination indicating the need for in-patient therapy is required before the admission may occur. Children admitted under this Act are also given notice of a broad array of substantive rights which they have been guaranteed by regulations promulgated under the Act. *See, e.g.*, "Bill of Rights", 6 Pa. Bull. 2119 §7100.1 10.3 (Sept. 4, 1976); 7 Pa. Bull. 1848 (July 2, 1977). In addition to rights of advocacy and grievance, all patients have the right to be discharged when they no longer need treatment, not to mention the statutory right to judicially challenge the validity of the admission at any time. 50 Pa. Stat. Ann. §7206.

This then is the general statutory and regulatory framework within which children may be admitted or committed to mental health facilities in Pennsylvania. It is indeed an understatement to note that there are substantial legal and practical impediments confronting parents intent on "dumping" a child in a Pennsylvania mental health facility, not the least of which is simply the scarcity of available beds.[9] In fact, Pennsylvania compares very favorably with most of her sister states in this regard. Appellants' examination of similar state statutes reveals that Pennsylvania's pre- and post-admission standards and procedures for juveniles, in terms of safe-

[9] Pennhurst Center for example has almost twice as many persons on its waiting list for admission than are actually in the facility receiving care.

guarding the interests of the child, equal or exceed those provided in most, if not all, of those states.[10]

[10] Statutes reviewed: 1976 Haw. Sess. Laws, Act 130 §334; Idaho Code Ann. §66-318, 66-320; Ky. Rev. Stat. §202A.020; Mass. Gen. Laws. Ann. ch. 123, §10, 11; Mo. Ann. Stat. §202.783, 202-.790 (Vernon); Nev. Rev. Stat. §433A.140, 433A.560; N.H. Rev. Stat. Ann. §135-B:11; N.J. Stat. Ann. §30:4-46, 30:4-48 (West); N.Y. Mental Hyg. Law §9.13; Okla. Stat. Ann. tit. 43A, §184 (West); Or. Rev. Stat. §426.220; Tenn. Code Ann. §33-601; Utah Code Ann. §64-7-29; Vt. Stat. Ann. tit. 18, §8807; Wis. Stat. Ann. §51.10 (West); Wyo. Stat. §25-3-106.

SUMMARY OF ARGUMENT

I. When a parent seek's medically recommended inpatient therapy for his child, no constitutionally protected liberty interest of the child is affected. Although there are limits to the autonomy that a parent enjoys from governmental interference in matters of child-rearing, they are not involved here. Inasmuch as there is absolutely no evidence of parental or professional irresponsibility here, there simply is no basis for displacing the traditionally recognized authority of parents and physicians to provide for the health needs of children. Parents, in conjunction with their physician, must not only be involved in these grave decisions, but they must be in control, absent the most compelling of circumstances. Even if, contrary to the evidence, we assume that parents and physicians occasionally conspire to remove a child from his home, the procedures mandated by the lower court will have little, if any curative effect in those cases.

Finally, as the record in this case clearly demonstrates, admissions to Pennsylvania facilities follow a very careful evaluation and diagnostic process. In fact, each of the named plaintiffs received several independent medical examinations and psychological evaluations prior to admission each of which concurred in the need for inpatient care. The procedures used in Pennsylvania are simply not deficient for Due Process purposes.

II. Admissions of a child to private facilities does not constitute 'State action' for purposes of the Due Process Clause. Pennsylvania plays no role in these admis-

sions except to license the facility to operate. The state's facilities, employees, or, in most cases, funds are not involved whatsoever.

III. The plaintiff and the defendant classes certified by the district court do not comport with the requirements of Rule 23(a) Fed. R. Civ. Pro. Both classes are permeated with a lack of homogeneity. In each class there are significant subgroups that have interests quite different from the class representatives, which interests were not, and could not have been represented by the named plaintiffs.

IV. The lower court's order for retroactive implementation violates the principles of federalism recognized by this Court in *Preiser v. Rodriguez,* 411 U.S. 475 (1973). Clearly, the plaintiffs in this case had the complete remedy of habeas corpus available to them, and at the very least, they should not have been permitted to attack the legality of their custody by the means of this civil rights action.

ARGUMENT

I. THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT IS NOT IMPLICATED WHEN A PARENT ADMITS HIS CHILD FOR MEDICALLY RECOMMENDED IN-PATIENT MENTAL HEALTH OR RETARDATION TREATMENT

A. Liberty Interest of the Child:

The relationship between parents and their children is deserving of, and has received special protection from this Court. Governmental intrusion upon the parental right to supervise and direct the upbringing of their offspring has not lightly been countenanced by this Court. Thus in *Stanley v. Illinois,* 405 U.S. 645 at 651 (1972), it was noted that:

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed 'essential,' Meyer v. Nebraska, 262 U.S. 390, 399 (1923), 'basic civil rights of man,' Skinner v. Oklahoma, 316 U.S. 535, 541 (1942), and '[r]ights far more precious . . . than property rights,' May v. Anderson, 345 U.S. 528, 533 (1953). 'It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.' Prince v. Massachusetts, 321 U.S. 158, 166 (1944). The integrity of the

family unit has found protection in the Due Process Clause of the Fourteenth Amendment, Meyer v. Nebraska, supra, at 399, the Equal Protection Clause of the Fourteenth Amendment, Skinner v. Oklahoma, supra, at 541, and the Ninth Amendment, Griswold v. Connecticut, 381 U.S. 479, 496 (1965) (Goldberg, J., concurring).

In short, the sanctity of this parental responsibility, as well as freedom, to direct the upbringing of their children is ". . . established beyond debate as an enduring American tradition". *Wisconsin v. Yoder,* 406 U.S. 205, 232 (1972).

This parent-child relationship is, of course, the touchstone of the notion of a family's right of privacy under the Constitution. In *Roe v. Wade,* 410 U.S. 113 at 152-3 (1972), Mr. Justice Blackmun pointed out that:

> [The] decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty', Palko v. Connecticut, 302 U.S. 319, 325 (1937), are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to marriage, Loving v. Virginia, 388 U.S. 1, 12 (1967); procreation, Skinner v. Oklahoma, 316 U.S. 535, 541-542 (1942); contraception, Eisenstadt v. Baird, 405 U.S. at 453-454; id. at 460, 463-465 (White, J., concurring in result); family relationships, Prince v. Massachusetts, 321 U.S. 158, 166 (1944); and child rearing and education; Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925); Meyer v. Nebraska, [262 U.S. 390 (1922)]. 410 U.S. 113, 152-3 (1972).

This Court has been steadfast in this view, and only last term admonished against governmental intrusion into the ". . . private realm of family life which the state cannot enter." *Moore v. East Cleveland,* 431 U.S. 494, 97 S. Ct. 1932 (1977). Thus, for example, in *Wisconsin v. Yoder, supra,* the state's admittedly compelling interest in educating its youth was subordinated to the parents' contrary wishes.

Of course, there are reasonable limitations on the autonomy of parents in the supervision of their children. For example, one of the highest duties of parenthood is providing for the health needs of one's children. Nevertheless, in life threatening situations, courts, at times have reluctantly superseded the parents.* However, in other situations parental wishes concerning grave medical decisions for their children have not been disturbed in favor of the desires of well-intentioned public officials, *e.g. In the Matter of Quinlan,* 70 N.J. 10, 355 A.2d 647 (1976). Generally, it is only when parents abdicate their responsibility to safeguard their child's health in a life-threatening manner that the state will be permitted to involve itself. *In Re Green,* 448 Pa. 338, 292 A.2d 387 (1972); *In Re Sieferth,* 309 N.Y. 80, 127 N.E. 2d 820 (1955); *cf. Bykofsky v. Middletown,* 401 F. Supp. 1242 (M.D. Pa. 1975). The point is simply that courts will not, and should not, lightly allow governmental intrusions into any aspect of a family's privacy.[11]

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* See generally—Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy,* 86 Yale L.J. 645, 651-661 (March 1977).

[11] Noting that "nothing, not even magic, can qualify a judge to make [non-life or death medical decisions] with equal or greater accuracy than the parent," Professor Goldstein strongly criticized

In this case each of the appellees' parents sought medical help for what they perceived to be mental illness or retardation. Ultimately, in each case medical experts recommended residential treatment for the appellees. Each of the parents decided to follow this medical advice, and thereafter the children were, at various times, admitted to residential treatment facilities.[12] Without questioning the propriety of this decision, or even objecting to the treatment they were receiving, this lawsuit was instituted on the children's behalf by their guardian.[13]

The Appellees claimed, and the lower court found, that when their parents and physicians jointly decided that residential psychiatric therapy was in their best interest, they were unconstitutionally deprived of their 'liberty' under the Due Process Clause of the Fourteenth Amendment. Their theory is not complex: because they cannot come and go as they please, against the wishes of their parents and physicians, they are involuntarily hospitalized; and involuntary commitment in a mental hospital without a prior hearing and the right to counsel is, in turn, a denial of liberty without due process of law. Their argument's simplicity, ignoring the complex issues which are involved, was unfortunately subscribed to *in*

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just such an intrusion in *In Re Sampson*, 65 Misc. 2d 658, 317 N.Y.S. 2d 641 (Fam. Ct. 1970), *aff'd* 377 App. Div. 2d 668, 323 N.Y.S. 2d 253 (1971), *aff'd* 29 N.Y. 2d 900, 278 N.E. 2d 918, 328 N.Y.S. 2d 686 (1972).

[12] Nine of the plaintiffs, each being mentally ill, were admitted to Haverford State Hospital. Two were admitted to Polk Institute for the retarded, and one was admitted to Pennhurst Center for the retarded. Each of these is a state-operated facility.

[13] Appellees' guardian, appointed for this litigation by the district court, is their attorney in this litigation, as well as serving in that dual capacity for the entire remainder of the class.

toto by the court below. However, as is the case with most simple solutions to complex issues, it is fraught with grave difficulties.

In ruling in favor of the original plaintiffs, the district court made essentially three findings. First, it determined that Pennsylvania's procedure for the voluntary admission of juveniles for residential mental health treatment implicated a liberty interest, possessed by all children which was protected by the Fourteenth Amendment (794a-796a). Next the court concluded that parents may not "waive" this right on behalf of their child (796a). And finally it determined that in every admission of a child to residential care, all of the traditional procedural protections recognized under the Fourteenth Amendment must be afforded (843a-852a). In short, there could no longer be any voluntary admissions of children to in-patient psychiatric care in Pennsylvania. Without any substantial modifications [14] this reasoning was merely reaffirmed on remand from this Court.

The district court predicated its finding of a liberty interest on two points. First, the court found that when the parents decide to accept medical recommendations that the child receive in-patient care and admit the child

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[14] In determining the process which was due, the requirements of counsel and a judicial hearing were somewhat modified on remand. A "trained representative" and "independent unbiased tribunal" were substituted. Nevertheless it is doubtful that the changes are really significant. For example, the trained representative must be able to present evidence and protect the child's rights to confront and cross-examine adverse witnesses. Similarly, the strictures placed upon the "independent unbiased tribunal" are such that Pennsylvania has no alternative but to resort to the courts (1057a).

for that purpose, ". . . the child is involuntarily removed from his home and familiar surroundings . . ." (794a). Secondly, the court found that such a hospital admission entails a severe stigma which may exceed even that which is associated with a criminal conviction (795a).

Both of the underpinnings for this threshold determination are seriously flawed. The conclusion that the appellees were "involuntarily" removed from their home ignores the central fact of this litigation—that they are children. Without exception, the experts in this case agreed with the seemingly common place notion that children, and certainly those of tender years, lack the developmental capacity to be entrusted with such important medical decisions.[15] Dr. Leon Eisenberg, Professor of Psychiatry at Harvard University, put it well when he commented that "[i]t strains the imagination to conceive of a ten year old child able to decide for himself or herself the wisdom of a psychiatric admission any more than of an appendectomy or a blood transfusion."[16]

Fortunately each of us, as youths, have from time to time been "victimized" by parents and doctors in

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[15] *See, e.g.*, Armstrong 86a; Sugar 367-8a, 411a, 421a, 435a, 437a-438a; Tashjian 652a; Miller 678a, 699; Masterson 722a.

[16] Eisenberg, *An Epidemic of Kew Gardens Syndrome: The Redefinition of Caring as Coercion*, International Symposium of the Thistletown Regional Center (September 1977)—to be published in *New Directions of Children's Mental Health*, Spectrum Publications (1978). The same point was recently made by the President of the Connecticut Council of Child Psychiatrists commenting on proposed legislation in that state which would have required hearings for all juvenile admissions for in-patient care. Futterman, *Bill No. 384—Civil Commitment of Mentally Ill Minors*, Academy of Child Psychiatry Newsletter (June 1978).

health matters. Against our wishes, we have all as children been subjected to necessary and at times uncomfortable medical treatment which may have appeared callously inflictive. Nevertheless, this is as it must be. In this country, an element of freedom is the right of a competent adult to accept or reject health services *Winters v. Miller,* 446 F.2d 65 (2d Cir. 1971), cert. denied 404 U.S. 985 (1971). Children on the other hand are not accorded this level of responsibility. Accordingly, it has been noted that none of the states have laws which compel a physically ill individual to be involuntarily hospitalized merely because he needs treatment to protect his own welfare. (Note: *Developments In the Law: Civil Commitment of the Mentally Ill,* 87 Harv. L.R. 1190, 1216 n. 84 (1974). Furthermore, no court has ever ordered a competent adult to accept such hospitalization and medical treatment solely for his own benefit. *Compare, Application of President and Directors of Georgetown College,* 331 F.2d 1000 (D.C. Cir. 1964), *Winters v. Miller, supra.* But the necessary counterpart to this freedom to refuse treatment is the responsibility to authorize or consent to treatment. And as noted above, this authority has traditionally been lodged exclusively with competent adults. *See, E.g., Bonner v. Moran,* 126 F.2d 121, 75 U.S. App. D.C. 156 (1941).

This curtailment of voluntary action by children is apparent in other areas as well: *e.g., Oregon v. Mitchell,* 400 U.S. 112 (1970) (voting); *Belloti v. Baird,* 428 U.S. 132 (1976) (termination of pregnancy); *Ginsberg v. New York,* 390 U.S. 629 (1968) (reading materials); *Prince v. Massachusetts,* 321 U.S. 158 (1944) (earning money). Nevertheless, in the district court's view, admission of a child for in-patient treatment or habilitation is

different. While no constitutionally protected liberty interest is implicated if a parent decides, upon medical advice, to authorize the most risky of surgical procedures for his child,—in the lower court's view such an interest is implicated for example, when a parent seeks to admit his child to a group home or community mental health center for in-patient care—be it only for several weeks.[17] Similarly, no one would suggest that a child's liberty is affected when his parents admit him to a military school to "straighten him out"—not so in the lower court's view if that school happens to be licensed or approved as a mental health facility.[18]

The reason for all of this is apparently the stigma which the district court perceived may be attendant with receiving mental health or retardation care (1076a-1077a). While no doubt there are those who still view mental affliction with fear and apprehension, great strides have been and continue to be made in this area. Nevertheless it is doubtful that the procedures ordered by the district court will in fact protect children from any stigma

[17] In Pennsylvania the range of mental health and retardation services covers the continuum from small family-like facilities, such as community based group homes and mental health centers, which serve only a few residents, to large state operated institutions. Admission to one is the same as the other for constitutional purposes under order in this case.

[18] For example, the Devereau Foundation operates private schools which are "approved" mental health and mental retardation facilities under Pennsylvania law. Nevertheless such facilities are far more akin to private schools than they are mental institutions—and in fact are viewed publicly as such. Nevertheless each of these students will now become a prospective mental health admission—but each will be given due process. In the words of Dr. Masterson we may well have provided each with his "civil rights at the cost of his human rights . . ." (723a).

that still lingers. First, it is doubtful, based upon the evidence, that the hearings will do much more than deter some people from receiving early medical intervention for a problem that will inevitably worsen. In other words, the whole procedure will be traumatizing, and may cause parents to avoid necessary care for their children altogether.[19] In addition the process which is intended to protect the child from stigma may indeed exacerbate it. One phychiatrist, describing a similar procedure which now exists in New Jersey, noted that:

> the children involved often react as if they have been disposed of through criminal channels. Children ask those who have attended court hearings, 'How many months did you get?' The children view themselves as being identified as criminals and in fact think that they themselves are criminals. One twelve-year-old in particular was quite terrified of going to court.[20]

In addition to this, it is doubtful that the procedures will accomplish very much in terms of avoiding erroneous admissions which may needlessly subject a child to such stigma.[21] First the available data tend to show that the independent factfinder rarely, if ever, disagrees with med-

[19] Armstrong 80a; Sugar 370a-71a; Tashjian 655a; Miller 688a; Masterson 723a, 728a.

[20] Perr, Irwin, M.D., J.D., *Minors and Institutionalization,* Society for Adolescent Psychiatry, Inc., Newsletter (January 1978).

[21] There is no contention here that the appellees were needlessly receiving care. In fact none has yet sought to terminate their therapy—although several have completed their treatment and been discharged.

ical recommendations.[22] Once again, describing a system similar to that which was imposed by the district court in Pennsylvania it was reported that:

> Children were transported for court hearings in the cold marble palaces of justice where their confused and angry parents found themselves under scrutiny and attack. Local attorneys found that their court-appointed activities, if perfunctorily performed, provided modest but reliable remuneration. Initially the attorneys knew little of the issues as did the judges and the complex procedures were in reality a costly and time-consuming ratification procedure.[23]

Furthermore, any stigma which still exists with respect to mental illness or retardation is a reaction to the affliction rather than to its treatment. These prejudices will not be eliminated, nor their injurious effects avoided, by interposing legal proceedings of questionable value as a precondition to that treatment. Thus, it is clear that, as in all other areas of medical treatment, children have no constitutionally protected "liberty" interest, independent of their parents, which is adversly affected when that

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[22] Wengler & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. of Health & Social Behavior 66, 68 (1969). Moreover, Dr. Barbara Armstrong, a psychiatrist at Haverford State Hospital, testified that in her experience at Haverford she had seen only one real error in a medical diagnosis for institutional treatment, *and that followed a complete judicial hearing* (95a-96a).

[23] Perr, *Minors and Institutionalization, supra* at 2. See also Meisel, Roth, *The Child's Right to Object to Hospitalization—Some Empirical Data*, 4:3 Journal of Psychiatry and Law, 377-392 (Fall 1976).

parent authorizes medically recommended residential mental health treatment.

B. Waiver by the Parents:

Having decided that the parents' actions in this case had affected a Constitutionally protected right to liberty possessed by their children, the district court then looked to whether or not such rights could be waived by the parents (796a). Notwithstanding the involvement of rudimentary traditions of parental autonomy in matters of child rearing, and presuming "that in most instances parents [act] in [their] child's best interests . . ." (797a), the district court nevertheless determined that a child's parents and physician may never be entrusted with the responsibility for obtaining necessary inpatient care for that child (797a). The singular basis for this conclusion was its speculation, without any evidence of parental or medical irresponsibility whatsoever, that parents "may at times be acting against the interests of their children" (798a).

In effect a presumption of child abuse or, at a minimum, parental irresponsibility, has been raised every time a parent and physician jointly decide that in-patient psychiatric treatment is medically necessary. This flies in the face not only of centuries of Western tradition and culture, but is also contrary to most of the expert testimony placed before the district court.[24] Dr. Eisenberg makes the point well:

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[24] *E.g.*, Sugar 381a, 418-420a; Kandler 554a; Ingall 591a; Miller 692a-693a. See also Futterman, *Bill No. 384—Civil Commitment of Minors, supra* at 11; Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy, Supra.*

> That a number of parents do abuse their children and may wish to be rid of them at all costs does not contravene the correctness of assuming good will as the starting point. The new doctrine stands the world on its head. In the effort to prevent the violation of some, it does violence to all.[25]

Admission of a child for mental health or retardation therapy is, and should be, a very serious matter. Without a doubt, the consequences of an erroneous decision in this regard may be profound. It is just this type of a difficult decision that must be left to the family and physician, with a minimum of bureaucratic interference. Parents must be intimately involved, indeed, in control of the situation. In grave matters such as these we must not be tempted to take the easy route, and allow the government to make the decision. To do so, and follow the "new doctrine" established by the district court would make ". . . bystanders of us all, bystanders who rationalize uninvolvement by pious murmers about freedom."[26]

Thus, as the foregoing attests, the entire rationale for the district court's finding of a constitutionally protected "liberty interest" is misconceived. Children are simply not adults, and the law should not treat them as such. Medical decisions, and especially those of the grave nature involved here, must be left to the family in consultation with their physician. While there are doubtlessly adverse consequences which attach to mental affliction, that alone is not sufficient to displace all parental decision-making authority in this area. In short, the lower court's approach is wrong and must be reversed.

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[25] Eisenberg, *An Epidemic of Kew Gardens Syndrome: The Redefinition of Caring as Coercion, supra* at 9.

[26] Eisenberg, *Id. supra* at 10.

C. The Process Due:

After determining that the admission of a child for in-patient care did involve an aspect of that child's right to "liberty" under the Fourteenth Amendment, and that parents could not waive that right, the district court decided that the process due these children included a full range of adversarial procedures. Its determination in this regard reflects certain fundamental misconceptions, and ignored the evidence of a very careful and deliberate admission procedure which was involved for each admission in this case.

The lynchpin of the district court's reasoning is this Court's opinion in *In Re Gault,* 387 U.S. 1 (1966). However, *Gault* and its progeny which deal with juveniles' rights in the criminal area, have no application here however. Juveniles' procedural rights have been scrutinized by this Court in a series of cases beginning in 1948 with *Haley v. Ohio,* 322 U.S. 596 (1948), and continuing through the decision in *Breed v. Jones,* 421 U.S. 519 (1974). The clear trend of those decisions has been to require carefully selected procedural safeguards which have been deemed essential to fundamental fairness in criminal proceedings for adults. *McKeiver v. Pennsylvania,* 403 U.S. 528 (1970). This has been a disquieting process, for the Court has continued to recognize the implications of a more formal criminal justice system for juveniles. Thus, this Court in *McKeiver* avoided a "remake [of] the juvenile proceeding into a fully adversary process . . .", *Id.* at 545. Nevertheless, the harsh realities of the unfulfilled aspirations of the present system, *Breed v. Jones,* supra at 528, and the essentially criminal nature of juvenile proceedings have necessitated these reforms.

This Court has accordingly required that juveniles be afforded the rights of notice, counsel, confrontation and cross-examination in delinquency proceedings. *In Re Gault, supra.* Moreover, proof of delinquency is required to meet the traditionally heavy burden of beyond a reasonable doubt. *In Re Winship,* 397 U.S. 358 (1970). Similarly, in *Haley v. Ohio,* 332 U.S. 596 (1948), and in *Gallegos v. Colorado,* 370 U.S. 49 (1962), coercive procedures used in obtaining confessions from juveniles were ruled unconstitutional. However, this Court has not required that all rights Constitutionally guaranteed adults charged with a crime be made available to juveniles similarly accused. Thus for example, in *McKeiver* the Sixth Amendment right to trial by jury was not imposed upon the juvenile justice system.

The consideration of overriding importance which is derived from these cases is abundantly clear. Procedures required in the adult criminal process which go to the integrity of the fact-finding determination, the "was it done and did the defendant do it" determination, have been generally imposed on the juvenile justice system. Thus, confessions elicited under questionable circumstances, normally of dubious reliability, became even more unreliable when extracted from a child. *Haley, supra; Gallegos, supra.* Similarly, it was noted in *Gault* that "[w]ith respect to juveniles, both common observation and expert opinion emphasize that the 'distrust of confessions made in certain situations' . . . is imperative in the case of children from an early age through adolescence." *Id.* at 48. Similarly, a determination of a defendant's guilt or innocence is extremely suspect if that defendant has been denied the right to effectively challenge those findings through confrontation and cross-

examination, with counsel's assistance. *Gault, supra.* However, in further application of this principle in *McKeiver,* this Court concluded that "[t]he imposition of the jury trial on the juvenile court system would not strengthen greatly, if at all, the fact-finding function . . .". *McKeiver, supra* at 547.

The misstep in the lower court's approach in relying on *Gault* is apparent—it fails to distinguish between a medical diagnosis of mental illness or retardation, along with a recommendation for in-patient treatment, and a finding of guilt in a criminal proceeding. In the lower court's view, equating the two was justified because of the need to guard against inaccurate medical diagnosis in this area. Thus, for constitutional purposes, the district court would view the relationship between a child and his parents as equivalent to the relationship between the State and a child it accuses of criminality. There is nothing in *Gault* or any other decision of this Court which would support such a result.

The joint decision between a parent and physician to admit a child for in-patient treatment is a medical decision which is predicated upon careful medical evaluation. The critical "fact-finding" in the process is a medical diagnosis rather than an adjudication of guilt or innocence. If judicial evaluation of a recommended medical treatment plan is the underlying purpose for which the adversary proceeding ordered below is intended—and surely it is—then the timeless description of the juvenile court system rendered sixty years ago by Roscoe Pound will equally befit the courts that participate in this venture. After examining the system of juvenile justice Professor Pound found it to be ". . . an enterprise origin-

ally designed to use power and authority of law to achieve ends not amenable to legal means."[27]

An accurate medical diagnosis in the mental health area does not depend so much on whether a particular event actually occurred or whether that child actually did it. Rather the key is a medical evaluation predicated upon professional assessments of a multitude of factors. This may or may not involve some factual determinations.[28] But just as courts do not insist upon second-guessing a medical diagnosis in the area of physical medicine, they should be equally loath to do so in the area of psychiatry. Furthermore, factual determinations are a part of the diagnostic practice in physical medicine no less than in psychiatry. Thus, when a mother brings her two year old child to a doctor and explains the child's symptoms —mental, physical or both—a court hearing to check the accuracy of the mother's reports or the doctor's diagnosis and recommended treatment, is unwise, unwarranted, and without precedent.

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[27] Lemert, *Instead of Courts, Crime and Delinquency, citing* Roscoe Pound, the "Limits of Effective Legal Action": Twenty-Second Annual Report of the Pa. Bar Association, *National Institute of Mental Health,* 221, 225 (1971).

[28] These factual determinations in some cases may even involve the accuracy of reports of various conduct that could be classified as delinquent or criminal (790a). Moreover this conduct, or even reports of this conduct, may have even been the impetus for a child's parents to seek psychiatric help. But that is not to say that the child is hospitalized *because* of these reports, Thus the lower court's statement that children were institutionalized for truancy may be no more accurate than the statement that a person had heart surgery for chest pains—surely the chest pains brought the patient to the doctor and such a notation would undoubtedly appear on his admission note—but that of course is not the whole picture. (Tashjian at 650a-652a).

The lack of precision in psychiatric diagnoses has been made much of, and in many quarters, greatly exaggerated.[29] Nevertheless, to the extent that there is some degree of variability in diagnoses among mental health and retardation clinicians, that degree of variation is not unique to psychiatric medicine.[30]

In any event, it is unlikely that the adversarial procedure that has been appended to the medical diagnosis will accomplish much more than being ". . . a costly and time-consuming ratification procedure."[31] If the detection of mental illness or retardation is difficult for those specifically trained in the field, lawyers and judges will undoubtedly prove even less capable.[32] Thus, as in the field of education, the joint decision to admit the child for in-patient care ". . . requires an expert evaluation of

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[29] The conclusions reached in Rosenhan, *On Being Sane in Insane Places,* 179 Science 250 (1973), seems to cast doubt on the ability of psychiatrists to diagnose mental illness, and is repeatedly relied on for that proposition. However this study has however come under strong criticism. E.g. Roth, *Some Comments on Labelling,* 3 Bulletin of the American Academy of Psychiatry and the Law, 123-131 (1975).

[30] Meehl, *Why I Do Not Attend Case Conferences,* Psychodiagnosis—Selected Papers, 273-274 (Univ. Minnesota Press; 1973); Beck, *Reliability of Psychiatric Diagnosis: A Critique of Systematic Studies,* American Journal of Psychiatry, 210-216 (1962).

[31] Perr, *Minors and Institutionalization, supra* at 2. See also Wengler & Fletcher, *The Effect of Legal Counsel On Admissions to a State Menial Hospital: A Confrontation of Professions,* 10 Journal of Health & Social Behavior 66, at 68 (1969).

[32] Dr. Roth of the University of Pittsburgh has noted that "[i]f psychiatric diagnoses are neither reliable nor valid, . . . then of course courtroom prediction and courtroom diagnosis should cease immediately." *Some Comments on Labelling, supra* at 128.

cumulative information and is not readily adopted to the procedural tools of judicial or administrative decision-making." *Board of Curators of Univ. of Missouri v. Horowitz*, 98 S.Ct. 948, 955 (1978).

More importantly, none of the appellees ever questioned the accuracy of the medical diagnosis in their particular case—nor have they questioned the mode of treatment they have received. In fact the record clearly demonstrates that in each case the admission was premised upon, not one, but a series of thorough examinations and evaluations constantly underscoring the need for treatment. Pennsylvania law requires that an admission be preceded by at least one, and sometimes two[33] independent psychiatric or psychological[34] examinations demonstrating the need for hospitalization. The fact of the matter is that in this case each appellee received an average of more than three such examinations. For example, Nancy D. received two separate medical examinations and three different psychological evaluations, each of which was conducted separately, at different times, and concurred in Nancy's need for in-patient treatment.[35] Similarly, in addition to a complete neurological evaluation, Francis B. received two separate medical examinations, as well as a complete psychological assessment, prior to even being accepted at Haverford Hospital for treatment.[36] Furthermore, in each case there was a pre-admission interview or conference whereupon the facility determined the suitability of placement for itself.

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[33] Applies only to the mentally retarded.

[34] Applies only to the mentally retarded.

[35] Defendants' Exhibit No. 2.

[36] Defendants' Exhibit No. 9.

By all standards the lower court's assessment of "what process was due" missed the mark. *Matthews v. Eldridge*, 424 U.S. 319 (1976).[37] First, as the foregoing demonstrates beyond peradventure, each of the plaintiffs was admitted for treatment only after a thorough and exhaustive evaluation of the necessity for such treatment. The facts are that the appellees' interest in not receiving in-patient care needlessly was scrupulously protected by all concerned. The record in this case simply does not warrant the adversarial procedures imposed by the district court.[38] Secondly, it is clear that these newly mandated procedures will do very little to enhance the diagnostic process and thus avoid erroneous admissions for treatment. *Board of Curators, Univ. of Missouri v. Horowitz, supra.* In fact there is a substantial probability that the mandated procedures will at once be needlessly traumatizing for the entire family[39] dangerously delay, and in some

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[37] The measure of the process that may be due in a given situation lies in the balance of three factors: the private liberty or property interest, the risk of an erroneous deprivation of the interest, and the Government's interest. *Matthews v. Eldridge, supra.*

[38] Even assuming that there is an occasional erroneous admission, nowhere in evidence here, Dr. Eisenberg's query points to the flaw in the district court's approach:

> "Is it too much to suggest that the ineptness or even venality of some doctors or lawyers does not warrant the implication that all are so?" Eisenberg, *An Epidemic of Kew Gardens Syndrome: the Redefinition of Caring as Coercion supra* at 8.

[39] *Recognition and Protection of the Family Interests in Child Abuse Proceedings*, 13 Journal of Family Law 803 (1973-74); Record at 566a, 636a, 655a, 687a, 689a-690a, 697a-699a, 727a.

cases prevent, the child's treatment;[40] and only heighten the negative societal attitudes which unfortunately still attach to mental affliction in some quarters.[41]

Finally, Pennsylvania has a number of very practical concerns which argue forcefully against affirming the district court's order. The injurious, if not fatal, blows this order will deal to the community and respite care programs have already been noted. Additionally, it takes no citation of authority to offer that there is a scarcity of mental health and retardation resources throughout the nation, and Pennsylvania is no exception. Nevertheless the district court has ordered the diversion of some of the

[40] Futterman, *Bill No. 384—Civil Commitment of Mentally Ill Minors, supra* at 11. In addition to placing a tremendous strain on Pennsylvania's attempt to foster a growing network of community based treatment facilities which are privately operated for the most part, the order all but ends its program of respite care 7 Pa. Bull. 1433 (May 28, 1977). Under this system parents who assume the responsibility for caring for their retarded youngster may utilize state facilities for up to thirty days annually in order to obtain some necessary relief from the rigors such a responsibility entails. In this respect the District Court entirely misconstrued just such an admission as being evidence of callous disregard for the child (790a). In fact such respite admissions are favored because they allow the family to avoid or, at least, delay the admission of the child for full-time residential care. In describing the very situation which was mispereceived by the district court, Dr. Irwin N. Perr noted that "this procedure was not the capricious act of cold-hearted parents but rather part of a specific program to keep such children at home while at the same time providing some relief from the burden of constant supervision by the parents." *Some Recent Legal Psychiatric Developments in the United States, supra* at 139.

[41] *Bill No. 384—Civil Commitment of Mentally Ill Minors,* Futterman, *supra;* Snyder, *The Impact of the Juvenile Court Hearing on the Child, Crime and Delinquency,* 180, 181, 188 (April 1971).

most scarce resources, psychiatrists and psychologists, to adversary proceedings which will ultimately have little or no value in the treatment of the youngster.[42] In addition, the financial cost of this complicated process will indeed be substantial, and, when compared with the benefits to be yielded, becomes prohibitive. For all of these reasons then it is clear that by present Due Process standards Pennsylvania's system for the admission of children to mental health facilities by their parents or guardians is entirely sufficient thus necessitating reversal of the lower court.

II. ADMISSIONS OF CHILDREN TO PRIVATE FACILITIES BY THEIR PARENTS OR GUARDIANS DO NOT CONSTITUTE "STATE ACTION" FOR PURPOSES OF THE FOURTEENTH AMENDMENT

Private action is immune from the reach of the Fourteenth Amendment. Furthermore, the mere fact that an activity is subject to state regulation does not convert its action into that of the State for the purposes of the Fourteenth Amendment. *Jackson v. Metropolitan Edison Company,* 419 U.S. 345 (1974). *Moose Lodge No. 107*

[42] The hearing is specifically required to determine "whether, in fact, the child is mentally ill or mentally retarded" and if so whether the proposed method of treatment will be beneficial to the child (1081a). It is therefore obvious that, at a minimum, extensive medical testimony would be required for the tribunal to at least make an attempt at determining the accuracy of the diagnosis as well as the treatment which has been prescribed. See generally, *On the Voluntary Admission of Minors,* Michigan Journal of Law Reform, 189, 206 (Fall 1974).

v. Irvis, 407 U.S. 163 (1972). Before action can properly be attributed to the State, there must be a "sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Jackson, supra,* at 351. Similarly, "[a] state's mere acquiescence in a private action . . ." does not render that action the State's. *Flagg Brothers, Inc. v. Brooks,* 98 S. Ct. 1729, 1737 (1978). "[I]t is quite immaterial that the state has embodied its decision not to act in statutory form." *Id.* at 1738.

In Pennsylvania, when a parent seeks to admit his child to a private facility, the State plays absolutely no role in the admission process. Private practitioners conduct the examinations and ultimately recommend the treatment. The parents and physician jointly select the facility which is most appropriate, and that facility's staff determines whether the youngster will be accepted for treatment. The State's only connection with the entire transaction is the licensing or approval of the facility to dispense mental health or retardation services.[43] Nevertheless, the district court found that the requirements of the Due Process Clause applied in this situation, just the same as if the state facilities and state officials were involved (1071a-1072a).

This holding cannot withstand the scrutiny of any of the state action tests enumerated by this Court. For example, this Court found no state action in *Jackson,* even though there was admittedly pervasive state regulation of the utility's activity there in question. Similarly, in *Flagg Brothers* this Court refused to expand the "state

[43] 50 Pa. Stat. Ann. §4201(8); §7105.

action" notion to include an essentially private transaction which was expressly authorized by state law. Just as New York was not involved, for Fourteenth Amendment purposes, in the warehouseman's sale in *Flagg Brothers,* nor was Pennsylvania involved in racial discrimination in a private establishment possessing a state license to operate in *Moose Lodge No. 107 v. Irvis,* 407 U.S. 163 (1972), Pennsylvania is similarly not involved in a parent's decision to admit his child to a private facility to receive medically recommended treatment.

Beyond being required to meet minimum qualitative standards, private mental health and retardation facilities in Pennsylvania receive absolutely no state supervision of the manner in which they operate.[44] Pennsylvania law has merely codified the commonly accepted notion that parents may authorize necessary medical treatment for their children.[45] Similarly, Pennsylvania statutorily regulate the dispensing of alcoholic beverages and utility shut offs. Yet, while these situations entail no state action, *Jackson v. Metropolitan Edison Company, supra, Moose Lodge No. 107 v. Irvis; supra,* the district court found that the State was involved here.

These private facilities are not staffed with state employees, receive no public subsidy,[46] and, by law, are not

[44] *See*: 50 Pa. Stat. Ann. §4201(4), (8); §4202 and §7105.

[45] Mere codification by statute of longstanding practices does not convert such activity into actions of the state, even if such codification actually changes the procedures involved. See, *Bosse v. Crowell Collier and MacMillan,* 565 F.2d 602 (9th Cir. 1977); *Melara v. Kennedy,* 541 F.2d 802 (9th Cir. 1976); *Anastasia v. Cosmopolitan National Bank of Chicago,* 527 F.2d 150 (7th Cir. 1975).

[46] Pennsylvania however does contract for services with a few of these facilities on a purely purchase of services basis.

part of the State mental health and mental retardation system.[47]. In fact, Pennsylvania is not even provided any advance notice whatsoever of new admissions to these facilities. Pennsylvania simply has no role in admissions to private mental health and retardation facilities. Thus, the admission of a child to a private mental health facility is a private transaction for purposes of the Fourteenth Amendment—notwithstanding the lower court's finding to the contrary.[48] The finding of "state action" here simply ignores the realities of the admission process. The California Appellate Court, in a case factually similar to this one, determined that:

> The decision to admit a minor [to a private licensed mental health facility] was a private one

[47] 50 Pa. Stat. Ann. §4201(4); §4202.

[48] In *Briscoe v. Bock*, 540 F.2d 392 (8th Cir. 1976), the Eighth Circuit held that dismissal of a physician by a state-licensed private hospital did not constitute "state action". It was undisputed that the hospital was a tax exempt, non-profit corporation subject to *extensive* state regulation. The hospital also received substantial financial assistance from both the state and federal governments. Accord: *Madrez v. Sorel*, 558 F.2d 303 (5th Cir. 1977); *Taylor v. St. Vincent's Hospital*, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976); *Watkins v. Mercy Medical Center*, 520 F.2d 894 (9th Cir. 1975); *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873 (5th Cir.), *cert. denied*, 423 U.S. 1000 (1975); *Ascherman v. Presbyterian Hospital of Pacific Medical Center, Inc.*, 507 F.2d 1103 (9th Cir. 1974); *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974); *Doe v. Bellin Memorial Hospital*, 479 F.2d 756 (7th Cir. 1973); *Ward v. St. Anthony Hospital*, 476 F.2d 671 (10 Cir. 1973). *See also, Cannon v. University of Chicago*, 559 F.2d 1063 (7th Cir. 1976) (alleged discrimination in admissions procedures of private university; no state action found); *Fulton v. Hecht*, 545 F.2d 540 (5th Cir. 1977) (alleged civil rights violations by private kennel club; no state action found).

> between parents, doctor, and hospital. The state in no way became a party to this parental decision involving medical treatment for their minor child, any more than it would become party to a parental decision to send their child to a private boarding school, to summer camp, or to his room.

In Re John S., 135 Cal. Rptr. 893, 901, —— P. 2d —— (1977).

Nor does the "public function" doctrine apply in this case. There is no gainsaying that private hospitals provide a valuable service to those who seek help for mental problems, which service, in no small measure, benefits the community as a whole. However, we are not dealing with a service or obligation traditionally associated exclusively with sovereignty, such as eminent domain. This Court has recently rejected the invitation to expand the "public function" doctrine into a broad principle that all businesses "affected with the public interest" are state actions in all their actions, pointing out that:

> Doctors, optometrists, lawyers, Metropolitan and Nebbia's upstate New York grocery selling a quart of milk are all in regulated businesses, providing arguably essential goods and services, 'affected with a public interest.' We do not believe that such a status converts their every action, absent more, into that of the State.

Jackson v. Metropolitan Edison Company, supra at 354.

Similarly, the fact that Pennsylvania also provides mental health care in state operated facilities does not mean that private facilities providing similar care are sub-

ject to the same Constitutional requirements. This precise point was addressed in *Evans v. Newton,* 382 U.S. 296, 300 (1966):

> The range of governmental activities is broad and varied, and the fact that government has engaged in a particular activity does not necessarily mean that an individual entrepreneur or manager of the same kind of undertaking suffers the same Constitutional inhibitions. While a State may not segregate public schools so as to exclude one or more religious groups, those sects may maintain their own parochial educational systems.

In short, Pennsylvania has only recognized the parent's right to act; it does not require that such action be taken. A parent's "exercise of the choice allowed by law where the initiative comes from [them] and not from the State, does not make [their] actions in doing so 'state action' for the purposes of the Fourteenth Amendment." *Jackson, supra* at 357. All states have and must pass laws regulating many forms of private activity. Subjecting all behavior that merely conforms to State law to the Fourteenth Amendment would completely emasculate the entire state action concept. Following the guidelines articulated by this Court then, the district court's finding of state action in the admission to a private medical facility in Pennsylvania must be reversed.

III. THE DISTRICT COURT ERRED IN ITS TREATMENT OF BOTH THE PLAINTIFF AND DEFENDANT CLASSES

A. The Plaintiff Class:

Noting an "obvious lack of homogeniety" in the original plaintiff class, this Court previously advised that "we have the gravest doubts whether the class, as presently constituted, comports with the requirements of Fed. Rule Civ. Proc. 23(a)." *Kremens v. Bartley,* 431 U.S. 119, 130 (1976).[49] Accordingly, the district court was urged to "stop, look, and listen" before again certifying a class. The lower court was cautioned that "careful attention must be paid to the differences between mentally ill and mentally retarded, and between the young and the very young" Id. at 135-36.

Nevertheless the district court, after looking at these factors, made essentially no changes to the original class.[50] The lower court determined that the obvious dif-

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[49] As noted at the outset, the original class was certified as: "all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (783a)."

[50] The court did create two sub-classes:

> (a) all juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen:
>
> (b) all juveniles committed as mentally retarded to mental health facilities in Pennsylvania who are age eighteen or younger.

Nevertheless for purposes of determining liability and ordering relief the district court treated the mentally ill and the mentally retarded the same, just as it had originally (844a).

ferences between infants and adolescents, and the retarded and mentally ill were unimportant for class certification purposes. The Court speculated that the adverse consequences attendant with mental affliction, e.g., stigma and risks of institutionalization, may be suffered by both the mentally ill and the mentally retarded. Finally, in its view, the risk of an erroneous diagnosis, as well as a parental conflict of interest, might occur in either group (1067a-1069a). Thus both groups, the mentally ill and the mentally retarded,[51] as well as the adolescents and the infants, were accorded the same treatment.

Rule 23(a) requires that representatives of a proposed class share common questions of law or fact with the unnamed class members, claims typical of all, and that they adequately protect the interests of those they purport to represent. Fed. R. Civ. P. 23(a)(1)-(4). In short, parties may not "represent a class of whom they are not a part." *Bailey v. Patterson*, 369 U.S. 31, 33 (1962). So too, the representatives of the class must "possess the same interest and suffer the same injury" as all others in the class they purport to represent. *Schlesinger v. Reservists to Stop the War*, 418 U.S. 208, 216 (1974).

Putting aside what has already been said regarding any stigma that may exist, the unbased fear harbored by the lower court concerning a conflict of interest between parents and their children, and the inability of professionals in both fields to adequately diagnose and treat

[51] For a discussion of the special considerations of the retarded with respect to adversary hearings, see, *Vecchione v. Wohlgemuth*, F. Supp. , E.D. Pa. (No. 73-162, filed Feb. 1973) (memo approving settlement).

their patients—there are serious problems with this plaintiff class. The first is the lack of representation for those of tender years in the class. In fact the youngest mentally retarded representative is fourteen years old,[52] while the youngest mentally ill plaintiff is seven.[53]

The distinctions are critical. The factual and legal considerations vary markedly between an infant and an adolescent, and even between an infant and a school-aged child. For example, the effects of an adversarial hearing may be quite traumatizing and counter productive for a child of two years of age, while on the other hand having very little effect on the seventeen year old. Indeed this Court noted that:

> This distinction between older and younger juveniles, recognized by state administrative authorities (and later by the Pennsylvania Legislature in its enactment of the 1976 Act), emphasizes the very possible differences in the interests of the older juveniles and the younger juveniles. Separate counsel for the younger juveniles might well have concluded that it would not have been in the best interest of their clients to press for the requirement of an automatic precommitment hearing, because of the possibility that such a hearing with its propensity

[52] Accordingly each of these plaintiffs receives the benefits of the 1973 regulations while the younger class members do not (pages 9 to 15, *supra*). As this Court pointed out, lumping these two groups "ignore[s] the effect of the regulations promulgated by appellants which makes [this] dramatic distinction between older and younger juveniles . . .". *Kremens v. Bartley, supra* at 135.

[53] Paul M., a mentally ill child, was seven years old when this suit was initiated on his behalf (Defendants' Exhibit No. 6).

> to pit parent against child might actually be antithetical to the best interest of the younger juveniles.

Kremens v. Bartley, supra at 135.

Thus, just as the district court failed to recognize that infants need special care and protection from the family that should be disturbed in only the most compelling circumstances, so also did it fail to take special note of the problems peculiar to adolescence.[54]

Although the district court made repeated reference to the risks of institutionalization as, another basis for the class certification, the class that it certified goes much beyond that. In fact, included within the class are children who may annually receive no more than two or three weeks of in-patient care in a public or private facility, as well as the child who is receiving mental retardation therapy in a small family-like group home. Once again, the fact of the matter is that none of the named plaintiffs represents the interests of these diverse groups. Each of the representatives was admitted to a public institution, which institution bears little resemblance to a community based group home for example. Similarly few, if any, of the considerations recognized by the lower court apply to a child who, by virtue of one very short admission each year, is able to remain with his family for the remainder of the year. The compelling differences between institutional care and community based care, as well as between respite admissions and long term admission are obvious. *See, e.g. Halderman v. Pennhurst,* 446 F. Supp. 1295 (E.D. Pa. 1977). Because of this, those who have been admitted for treatment in an institutional setting for relatively long term care cannot ad-

[54] *See, e.g.* testimony of Sugar 367a-368a; Miller 678a, 699a.

equately represent the interests of those who have not. Accordingly the doubts which this Court had originally were well founded, necessitating reversal of the district court.

B. The Defendant Class:

In addition to allowing this case to proceed as a plaintiff class action, the district court also certified a defendant class composed of:

> The directors of all mental health and mental retardation facilities in Pennsylvania which are subject to regulation by the defendant Secretary of Public Welfare (956a).

All of the problems relating to a lack of homogeniety which were noted with respect to the plaintiff class, exist here as well. For example, this class not only includes the directors of state facilities who are employed by Pennsylvania, but also owners and operators of private facilities who are subject to absolutely no control by the Secretary, beyond licensing or approval. Some of these facilities are operated for profit, some are not—some may be similar to public institutions, while still others closely resemble middle class homes, or in some cases, private schools. The point is that just as with a plaintiff class, so too must the defendant representatives share a commonality of interests with all of the members of that class. So too must the defendant representatives be able to adequately defend the interests of the class members. *See: United States v. State of South Carolina,* 445 F. Supp. 1094, 1098 (D. S.C. Colum. Div.), *aff'd* 98 S.Ct. 756 (1978).

Examples of a lack of common interests within the defendant class abound.[55] While the state defendants will be able, through taxation, to ultimately fund the implementation of the order as it pertains to the public facilities, this is not so for the private facilities. Similarly, the state's administrative machinery might be utilized to provide hearings for admissions to public facilities, while the private facilities would undoubtedly be forced to resort to the courts. Likewise, the relief which was ordered, while amounting to a tremendous administrative burden for the State, may indeed be the death-knell to the very existence of any number of private facilities. In any event, the diversity of interest within the defendant class is clear. Accordingly, the district court must be reversed in this regard.

IV. THE RETROACTIVE ASPECTS OF THE LOWER COURT'S ORDER ARE IMPROPER[56]

Any person, regardless of age or affliction has a specific statutory right to test the validity of his admis-

[55] Generally, see testimony G. Radke, hearing on application for stay pending appeal, July 5, 1978.

[56] In light of the recent opinion in *Hutto v. Finney*, 46 U.S. L.W. 4817 (June 23, 1978), appellants no longer believe it necessary for this Court to consider whether the lower court's order violates the Eleventh Amendment to the United States Constitution. In *Hutto*, this Court found no constitutional violation in an award of fees and costs against the state based upon the bad faith of state officials. In so doing, the court clarified both the distinction, first noted in *Edelman v. Jordan*, 415 U.S. 651 (1974), between that retroactive relief barred by the Amendment and the prospective injunctive relief which is not, as well as the scope of proper "ancillary" costs. Similarly, the general availability of "compensatory" relief, approved in *Milliken v. Bradley*, 433 U.S. 267 (1977) as part of a court's broad powers in school desegregation cases, is now apparent. Since no "accrued monetary liability", Id. at 289 has been awarded, *Hutto* suggests that the lower court's order constitutes prospective injunctive relief proper under the Eleventh Amendment.

sion to a mental facility in Pennsylvania. 50 Pa. Stat. Ann. §4426, §7111(3) and §7206. The appellees in this case chose not to utilize these remedies but rather elected to institute this civil rights action. The single issue here is whether this was proper, or whether they were first required to pursue their state remedy under the principles laid down in *Preiser v. Rodriguez*, 411 U.S. 475 (1973). While plaintiffs' claims for prospective injunctive relief may have been appropriate in a §1983 action, *Gerstein v. Pugh*, 420 U.S. 103, 107 n. 6 (1974), their request for a retroactive injunction to apply to children then hospitalized was improper, and the court's order to that effect should be reversed. *See, e.g., Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975).

In *Preiser* several state prisoners brought a §1983 action alleging that they were unconstitutionally deprived of good conduct-time credits. They sought injunctive relief to compel the restoration of these credits which would have resulted in their release from prison. After noting various examples in which habeas corpus was the appropriate remedy, the Court noted that "in each case [the petitioner's] grievance is that he is being unlawfully subjected to physical restraint. . ." *Id.* at 486.

Since it was clear in *Preiser* that the complaint challenged the legality of their physical restraint, *Id.* at 487, the only remaining determination was whether or not

habeas corpus was the *exclusive* remedy by which they could proceed. This Court held that it was, and that therefore the plaintiffs' §1983 claims were barred for failure to exhaust their state remedies.

Federal exhaustion requirements apply to all cases where habeas corpus is an appropriate remedy.[57] Thus section 2254(b) merely refers to "a person in custody pursuant to the judgment of a state court". The fact that the appellees have not been committed by Court order is irrelevant. In *Preiser* this Court rejected a similar contention noting that an attack upon a state's administrative procedures by one seeking release is no less within the "core of habeas corpus" than an attack upon a prisoner's conviction, ". . . for it goes directly to the constitutionality of his physical confinement itself. . . ." *Id.* at 489. Habeas corpus was available to the plaintiffs in this case and in fact, would have been a complete remedy. *See, e. g., Hartman v. Scott,* 488 F.2d 1215 (8th Cir. 1973); *Heryford v. Parker* 396 F.2d 313 (10th Cir. 1968).

The appellees in this case were attacking the legality of their confinement. The complaint sought to enjoin the continued enforcement of the statute from which the appellants derived their authority to treat the appellees. Moreover, appellees' claims were predicated upon their expressed desire to be released from treatment. *See, e.g.,* 14a, 15a, 16a, 22a-23a. They were not challenging the conditions of their confinement, *Preiser, supra* at 498, nor have they sought damages. *Wolf v. McDonnell,* 418 U.S. 539 (1973).

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[57] 28 U.S.C. §2254(b) requires exhaustion of all state remedies before seeking habeas corpus in federal court.

The primary purpose for requiring exhaustion of state remedies is the concept of federal-state comity which is fundamental to "Our Federalism." *Younger v. Harris,* 401 U.S. 37, 44 (1971); *Preiser, supra* at 491. The lower court's order in this case ignored that principle by requiring complete retroactive application of its order. Such a clash can only be justified in limited cases. State law and procedure must obviously conform to the requirements of the Constitution, *Miranda v. Arizona,* 384 U.S. 436 (1966). But in this case it was clearly inappropriate for the lower court to order such a massive imposition upon the Commonwealth.

CONCLUSION

On the basis of the foregoing arguments and authorities, appellants respectfully suggest that the lower court must be reversed.

Respectfully submitted,

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